SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

COMMUNITY FIRST CHOICE Policy Manual	Section: FORMS
	Subject: Internal Quality Assurance Review Summary

PURPOSE

The purpose of the provider agency Internal Quality Assurance Review Summary (SLTC-252) is to capture information about an agency-based provider agency's internal quality assurance reviews. Internal reviews are one component of provider agency quality assurance reporting. (Refer to CFC/PAS 610).

REVIEW SAMPLE

1. The internal chart review must include all of the standards indicated in policy (Refer to CFC/PAS 610).

2. Determine the review sample. The review sample includes the Intake Review Sample; the Recertification Review Sample, and the Annual Review Sample. The following steps are required to determine the review sample:

    a. Identify the total member list for the month of December

    b. Intake Review Sample: List all member intakes from July-December

        i. Pull a 50% random sample of all intakes.
            1. This list becomes Intake Review Sample

    c. Subtract member intakes from total December member list (a). This is the total member sample size the provider agency will use to determine the review sample list percent.

    d. Recertification Review Sample: The number of charts in the review sample is based on the following:

        - Over 250 members: 25 member sample
        - 51-250 members: 10% member sample

- 0-50 members: 5 member sample

i. Pull a random sample of member charts based on the review sample size.
   1. This list becomes the Recertification Review Sample

Note: If the provider agency has regional offices the provider agency may conduct a stratified random sample for each regional office (Refer to CFC/PAS 610)

e. Annual Review Sample: Determine which members from the Recertification Review Sample had an annual visit between July-December

i. This list becomes the Annual Review Sample

3. Once the review sample has been determine, the agency is required to complete an internal review of member charts. Below is the breakdown, by review sample, of the standards that must be reviewed:

a. Intake Review Sample (2b): Member files must be reviewed for the following standards:

i. Standard 1: Intake Standard;

ii. Standard 4: Person-Centered Planning Standard (when the agency is the plan facilitator); and

iii. Standard 5: Health and Safety Standard.

b. Annual Review Sample (2e): Member charts must be reviewed for the following standards:

i. Standard 2: Recertification Standard;

ii. Standard 3: Annual standard;

iii. Standard 4: Person-Centered Planning Standard (when the agency is the plan facilitator); and

iv. Standard 5: Health and Safety Standard.

c. Recertification Review Sample: Member charts must be reviewed for the following standards:

i. Standard 2: Recertification Standard;

ii. Standard 4: Person-Centered Planning Standard (when the agency is the plan facilitator); and

iii. Standard 5: Health and Safety Standard.

4. The provider agency must have a tracking method to record the internal chart review results. The record must include the names and Medicaid ID of members in the sample broken down by the following:

   a. Standard and criteria that were reviewed; and

   b. Indication of whether the criteria were met, unmet, or N/A.

5. The provider agency must retain a record of the internal tracking documentation for verification purposes.

INTERNAL QUALITY ASSURANCE REVIEW (SLTC-252)

1. December Total Caseload: In the space provided indicate the total number of Medicaid CFC/PAS members who were served by the provider agency in the month of December.

2. Standard 1: Intake Total- In the space provided indicate the total number of intakes from July 1- December 31. Intakes should include all admits; including high risk, regular admits, re-admits and switch in agency.

3. Standard 1: Intake Review Sample- In the space provided indicate the total number of member charts included in the Intake Review Sample.

4. Intake Review- Sample charts must be reviewed for the following criteria:

   a. PCP Form: Determine whether the member chart contains a PCP Form (SLTC-200). If the chart doesn't contain the PCP form, the criteria is unmet.

   b. Service Plan: Determine whether the member chart contains a Service Plan (SLTC-170) and that it is signed and dated by the member, nurse supervisor, and plan facilitator. If chart doesn't

contain the Service Plan or the required signatures, the criteria is unmet.

c. Mountain Pacific Quality Health (MPQH) Overview and Service Profile: Determine whether the member chart contains the MPQH Overview and Service Profile (SLTC 154/155). If the chart doesn't contain the most current Overview and Service Profile, the criteria is unmet.

d. The following criteria should be evaluated when the member is enrolled as a high risk intake:

i. High Risk Service Plan: Determine whether the member charts contains a High Risk Service Plan and that the Service Plan was signed and dated by the member and the nurse supervisor. If the chart doesn't contain a High Risk Service Plan, or the required signatures, the criteria is unmet.

ii. High Risk Referral to MPQH: Determine whether the member chart contains a High Risk Referral Form (SLTC-154) with the bottom section of the form completed indicating high risk. If the form is not present, the criteria is unmet.

5. December Caseload Total Minus Intakes- Subtract the total number of intakes during July1-December 31 from the total December caseload and report it in the space provided.

6. Standard 2: Recertification Review Sample- In the space provided indicate the total number of member charts included in the Recertification Review Sample.

7. Recertification Review- Sample charts must be reviewed for the following criteria:

a. Recertification Form with Signatures: Determine whether the member chart contains the Recertification Form (SLTC-210) and that it is signed by the member and nurse supervisor. If the chart doesn't contain the form or required signatures, the criteria is unmet.

b. Recertification Form includes correct authorized units from Service Plan: Review the Recertification Form to determine whether units/hours are recorded on the line for "authorized

units". Next, refer back to the Service Plan that was in place when the Recertification Form was completed and determine whether the same "authorized units" are indicated on the Service Plan. If the authorized units are not completed on the Recertification Form, or the units are not the same as indicated on the Service Plan, the criteria is unmet.

c. Recertification Form includes correct utilization: Review the Recertification Form to determine whether units/hours are recorded on the line for "utilization" Next, refer back to the Service Delivery Records (SDR) for at least a two month period of time prior to when the Recertification Form was completed and determine whether the utilization that is recorded on the form is accurate. If the utilized units are not indicated on the Recertification Form, or the units are not the same as indicated in the review of SDR, the criteria is unmet.

d. Recertification visit occurred within six months of intake or annual: Review the date the Recertification Form was signed. Review the member chart and find the date the previous Recertification Form was completed. If the recertification visit did not occur within the sixth month from the month of the previous visit, the criteria is unmet.

8. Standard 3: Annual Review Sample - In the space provided indicate the total number of member charts included in the Annual Review Sample

9. Annual Review- Sample charts must be reviewed for the following criteria:

a. PCP Form: Determine whether the member chart contains a PCP Form (SLTC-200). If the chart doesn't contain the PCP form, the criteria is unmet.

b. Service Plan: Determine whether the member chart contains a Service Plan (SLTC-170) and that it is signed and dated by the member, nurse supervisor and plan facilitator. If chart doesn't contain the Service Plan or the required signatures, the criteria is unmet.

10. Standard 4: Person Centered Planning- When the Plan Facilitator is an agency representative, review the chart for the following:

a. If the member is an intake review for the following criteria:

i. PCP Form contains member/PR initials: Determine

whether the PCP Form has the member/PR initials on each of the lines indicating they have received and reviewed the CFC Handbook. If a line is missing the initials, the standard is unmet.

b. PCP Form contains member information in every box: Determine whether the form contains member-specific information in every box of the form. If there is a box that does not contain member specific information, the criteria is unmet.

c. PCP Form signatures: Determine whether the PCP form has signatures of the member/PR, Plan Facilitator and provider agency (when different than Plan Facilitator). If the required signatures are not present, the criteria is unmet.

11. Standard 5: Health and Safety- Review every member chart in the sample for forms, notes, etc. for the months of July-December for the following criteria:

a. Service Plan documents ADL and IADL tasks and frequency: Review the member's current Service Plan Schedule to ensure that activities of daily living (ADL) are listed and assigned a frequency. If ADL tasks are not listed and/or the frequency for the ADL task is not listed, the criteria is unmet.

b. Flexibility parameters implemented according to policy: Review the member's current Service Plan and the MPQH Service Profile that was current on the date the member's current Service Plan was completed. Determine whether the frequency of ADL tasks on the member Service Profile is the same as the ADL frequency on the member Service Plan. If the frequency is not the same, determine whether there is documentation to support the flexibility parameters that were implemented. If there is no documentation addressing the flexibility parameters, the criteria is unmet.

c. The following should be reviewed when a temporary authorization/amendment is completed as a result of a change in service need

i. Temporary authorization completed when change occurs: Review the member file for the completion of a temporary authorization when there is a change in service need. When a temporary authorization was completed, review the Service Plan to determine the temporary authorization section of the Service Plan has

been completed. The section must include:

1. Box marked indicating the type of change;
2. Start date and end date;
3. Total time in units of the change; and
4. Description of the change to ADL and IADL tasks.

ii. If any of the sections of the temporary authorization listed above (1-4) are not completed, the criteria is unmet. If the start date and end date is greater than 28 days, the criteria is unmet.

iii. New Service Plan implemented within 10 working days of receiving a MPQH amendment to the Service Profile: Review all temporary authorizations that were faxed to MPQH for an amendment. Review the file to determine whether a new Service Plan was completed within 10 working days of receiving the amended Service Profile from MPQH. If a new Service Plan was not completed within 10 working days, the criteria is unmet

12. For each criteria on the Internal Quality Assurance Report indicate the total number of member files reviewed for that criteria, the number of member files that met the criteria, the number of member files that didn't meet the criteria, the total percent that met the criteria, (i.e. total number of met divided by the total number of members) and provide any comments.

    a. When any of the criteria are not met at 100%, the agency must complete the Agency Action Plan portion of the Provider Prepared Standards (SLTC-253) and indicate how the agency took action or plans to take action to resolve the issue(s) and ensure agency compliance in future reviews. (Refer to CFC/PAS 925).

13. Missing Recertification Visit- If a member in the sample does not have a recertification visit from July 1-December 31, the provider agency must list the member name in the space provided. If the member has been discharged, the discharge date must be listed on the form. If the member was not discharged the provider agency must report the member on the Provider Prepared Standards in the Agency Action Plan (Standard 10) and document the agency's action plan to resolve the issue.

REPORTING

TIMEFRAME

The Internal Quality Assurance Review must be submitted to the Regional Program Officer by April 1 of each year in conjunction with the Provider Prepared Standards.